Virginia Medicaid
DOSE OPTIMIZATION
Prior Authorization Request Form

The intent of this initiative is to use the optimum dose of a product to fill a prescription. An example of this is to use one 10 mg Abilify tablet instead of two 5mg Abilify tablets to fill a prescription. If the quantity submitted on the claim is over 34 units for a 34-day supply then the claims will reject with an error message of "Quantity Exceeds Maximum of 34 - Physician Call 1-800-932-6648". In order for patients to receive more than a 34-day supply for these drugs, it will be necessary for the prescriber to complete and fax or mail this prior authorization request to First Health Services Corporation. The fax number and address are listed at the bottom of this form. Please complete this form in its entirety, sign, and date below. Incomplete requests will be returned for additional information.

Below is the full list of medications restricted to the dose optimization initiative.

Brand Name	Generic Name	Limitations
Abilify® 2mg, 5mg, 10mg, 15mg, 20mg	aripiprazole	1 tablet / daily
Adderall® XR 5mg, 10mg, 15mg	amphetamine; dextroamphetamine	1 capsule / daily
Adderall® XR 20mg, 25mg, 30mg	amphetamine; dextroamphetamine	2 capsules / daily
Concerta® 18mg, 27mg	methylphenidate	1 tablet / daily
Concerta® 36 mg	methylphenidate	2 tablet / daily
Lexapro® 5mg, 10mg	escitalopram	1 tablet / daily
Risperdal® 0.25mg, 0.5mg, 1mg, 2mg	risperidone	1 tablet / daily
Strattera® 10mg, 18mg, 25mg, 40mg, 60mg, 80mg	atomoxetine	1 tablet / daily
Zyprexa® 2.5mg, 5mg, 7.5 mg, 10mg	olanzapine	1 tablet / daily
Zyprexa Zydis® 5mg,10mg	olanzapine	1 tablet / daily

Use this form to request prior authorization for medications that are part of the Dose Optimization initiative

Prescribing physician:

Name: _____

Phone #: _____

Fax #: _____

Patient:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ Sex: _____

Pharmacy (if known): _____ **Phone:** _____ **&/or FAX:** _____

Drug Requested: _____ **Strength & Frequency:** _____ **Length of therapy:** ____

Please answer the following questions, as applicable, to obtain an approval for a PA:

1. Has the patient tried less frequent dosing but was not able to tolerate due to adverse effects?
   If so, list the dose attempted and the failure. _____

2. Does the patient dose require a quantity greater than 34 and this is the only way for the patient to get the prescribed daily dose? (i.e., Abilify 4 mg daily – would need 2 mg x 2).
   Please list the dose _____

3. The patient has a specific indication that requires higher than normal dosing.
   Please list the specific indications _____

4. Does the patient require 1 and ½ tablets (instead of using 2 different strengths)? Yes or No _____

5. Is the patient dose in the process of being titrated? If so, please give the timeframe that the titration is expected to last. _____

6. Is the patient receiving Risperdal® for Schizophrenia? If so, please indicate.

_____

7. Please indicate other reason(s) why a PA is requested.

_____

_____

Comments:

Prescriber Signature: _____ **Date of this request:** _____

FOR FIRST HEALTH USE

Comments: _____

Approved **Changed** **Denied** **Pending**

MAP RPh/tech: _____

NDC: _____

Date of Decisions: _____

Submit requests via phone, fax or mail to:

First Health Services Corp.
MAP Department
4300 Cox Road
Glen Allen, VA 23060

Tel: 1-800-932-6648
FAX: 1-800-932-6651

- Once this Fax form is received by First Health a response will be sent to the requesting physician within 24 hours.
- Submission of documentation does not guarantee coverage by the Department of Medical Assistance Services and final coverage decisions may be affected by specific Medicaid limitations.
- This form should be used only for Dose Optimization request and cannot be used for PA requests for any other programs such as weight loss drugs, step edit or PDL.